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W 000	INITIAL COMMENTS A recertification survey was conducted from February 6, 2007 through February 9, 2007. The survey was initiated using the fundamental survey process. A random sampling of eight clients was selected from a population of twenty-nine (29) clients with various disabilities. On February 8, 2007 at 10:49 AM, the survey was extended in the Condition of Client Protections. The findings were based on observations, interviews with clients, family members, facility staff, school and day program staff, as well as the review of client habilitation and administrative records, including incident reports. The results of the survey revealed the facility was not in compliance with the Condition of Client Protections.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's governing body failed to provide general operating direction over the facility as evidenced below: 1. [Cross Reference W149] The governing body failed to have an effective incident management policy to ensure client's safety and well being. 2. The governing body failed to clearly identify the administrator to whom allegations of mistreatment, neglect or abuse, as well as	W 104	1. (See W 149) 2. The agency is clear within its operational practice who the administration is for each of the programs. Every program has a Program Manager who acts as the administrator for their respective program. The Program Managers develop and are responsible for their programs' budget and in the case of the adolescent residential program the funding agencies (MAA, MRDDA) view the residential Program Manager/Residential Program Director (RPD) as an administrative position therefore the RPD is notified and signs all of the incident reports and investigations. Historically this has been the practice. The revised policy will reiterate that the Program Managers are the administrator for their respective program by 3/21/07.	3/21/07

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Charles H. Harper Jr. Program Manager 3/16/07

Signature Date

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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W 104	Continued From page 1 injuries of of unknown origin should be reported and to whom the results of investigations should be reported. [Cross Refer to W153 and W156] Interview was conducted on February 6, 2007 with the Residential Program Director (RPD) to determine the administrator to whom allegations of abuse, neglect and mistreatment, as well as injuries of unknown origin, should be reported. Additionally, inquiry was made of the RPD concerning to whom the results of investigations should be reported. The RPD indicated that he reviews and signs the reports of unusual incidents involving the clients living in the residential facility. It should be noted that interview with the Director of Quality Improvement (QI) on February 8, 2007 confirmed that the RPD signs the unusual incident reports and investigations for the residential population. She, however indicated that allegations of abuse, neglect and mistreatment are reported to the administrator, the Chief Executive Officer (CEO). Although the majority of the reports were signed by the RPD, there was no indication or documented evidence verifying that the administrator (CEO) had reviewed/signed the incidents/investigations, or that the CEO had designated the RPD to act as the administrator. 3. Cross Reference W125 and W264. The governing body failed to ensure that the use of locks on all main entrances to the residential facility for all clients was reviewed by the agency's Human Rights Committee. 4. Cross Refer to W429. The governing body failed to ensure the temperature of the Rainbows	W 104	3. The Human Rights Committee reviewed the policy on 3/15/07 4. The concerns outlined in this statement of deficiencies were reported to the facilities department and this problem was solved before the survey was completed 2/9/07. The Facilities department will ensure that an equipment check and weather proofing occurs in fall prior to winter and in spring prior to summer.	3/15/07 2/9/07

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W 104	Continued From page 2 Living Unit and the hallways were maintained within a normal comfort range in the residential facility.	W 104		
W 112	483.410(c)(2) CLIENT RECORDS The facility must keep confidential all information contained in the clients' records, regardless of the form or storage method of the records. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to keep confidential all information contained in the clients' record for three of eight clients included in the survey (Client #6, #9, and # 10) The findings include: 1. [Cross refer to W120, 2]. The facility failed to ensure Client #6's therapeutic dietary information was kept confidential. 2. The facility filed to ensure that the dietary information of Clients #9 and #10 was kept confidential. Observation of the bulletin board in the Voyagers apartment during breakfast on February 7, 2007 revealed the feeding protocols were posted. Interview with staff indicated the information is posted to provided guidance to all staff caring for the clients. There was no evidence a system was implemented to ensure that the clients' personal information regarding dietary needs was only available for the individuals assigned to care for the clients.	W 112	The QMRP removed all posted diet and retrained staff on meal time protocols. All client personal information is placed in their individual program books. 1. The diet order was removed from the bulletin board at United Cerebral Palsy and placed in a program folder. NCC trained staff on confidentiality of medical information on 3/14/07 2. The dietary information was removed from the bulletin board and placed in their program folder. Staff was trained regarding confidentiality on 3/14/07.	3/14/07 3/14/07 3/14/07
W 114	483.410(c)(4) CLIENT RECORDS	W 114		

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W 114	Continued From page 3 Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that each individual making entries into a clients record signed and dated them, for two of the eight clients (Clients #5 and # 6) included in the sample. The finding includes: 1. Interview with the residential staff and review of Client #5's record on February 8, 2007 revealed the client had a BSP. Review of the BSP in his habilitation records revealed the plan was dated September 7, 2005. Closer examination of the plan revealed it was neither signed nor dated by the licensed psychologist. Further interview with staff on February 8, 2007 revealed that there was another copy of a BSP for Client #5 dated February 6, 2006. Additional review of this plan revealed that it too had neither been signed nor dated by a licensed psychologist. At the time of the survey, the facility failed to ensure Client #5's BSP had been signed. 2. Review of Client # 6's Individual Support Plan (ISP) book conducted on February 8, 2007 at approximately 10:20 AM revealed a client's rights form that was not signed and dated. Interview with the Qualified Mental Retardation Professional on February 9, 2007 at approximately 11:25 AM acknowledged that she had not signed on dated the client's rights form.	W 114	1. A signed and dated copy of client #5's plan was placed in his habilitation records on 2/10/07. unsigned or undated assessments will be clearly marked as drafts. 2. A signed copy of the client's rights form was placed in her program folder 3/14/07. This individual does not have a legal guardian at this time. A petition for a medical guardian was filed in June 2006.	2/10/07 3/14/07
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES	W 120		

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W 120	Continued From page 4 The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that eight of eight clients in the sample (Client #1, #2, #3, #4, #5, #6, #7 and #8) were provided outside services in accordance with their needs. The findings include: 1. The day program failed to ensure Client #7 was offered the opportunity to use various types of eating utensils during meals. During observation of the lunch meal at the day program on February 07, 2007, Client #7 was provided with a plastic spoon to eat her 1600 calorie low cholesterol diet. Interview with the day program instructor indicated that the client preferred to use the plastic spoon. Further interview revealed that forks and knives had never been provided for the client to use at mealtimes. There was no evidence the client was assessed to determine her ability to use a fork or knife during mealtime. 2. The day program failed to ensure Client #6's dietary information was kept confidential. Observations conducted at the Day Program on February 7, 2007 at 11:02 AM revealed a bulletin board on the class room wall. Posted on the board was Client #6 ' s personal information that indicated that she was on a Special Diet. Any visitor entering the class is able to view this information on the bulletin board. Interview with	W 120	1. QMRP has met with school program on 3/6/07 to address giving choices and using appropriate eating utensils. Client # 7 will be offered all utensils during mealtime. An OT assessment of client #7 abilities is scheduled for. The QMRP met with the day program on 3/13/07. See W 112. QMRP Assessed client # 6's ability to wipe her mouth when asked. Client # 6 demonstrated the ability to wipe her mouth w/ verbal and gestural cues.	3/6/07 3/21/07

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W 120	Continued From page 5 the Qualified Mental Retardation Professional (QMRP) on the same day at approximately 2:30 PM acknowledged that Client #6 ' s information should not have been posted on the bulletin board. 3. The day program failed to implement effective measures to address Client #6's drooling. Observation at Client #6 ' s day program February 7, 2007 at 11:06 AM, revealed the client in her treatment area seated on a chair located against a wall. The client was observed wearing a white bib that was stained. At approximately 11:13 AM, a female staff member asked Client #6 to wipe her mouth. The client did not respond. Shortly thereafter, a male staff member asked her to wipe her mouth and then prompted her by touching her left hand and directing her to wipe her mouth with the stained bib. Interview with the day program Support Staff Coordinator on the same day at approximately 11 :02 AM revealed that there was no program in place to assist Client #6 with wiping her mouth using the appropriate materials (i.e. napkins, paper towels). Interview with the QMRP at the residential facility revealed that Client #6 wipes her mouth independently. At no time did the support staff offer Client #6 a napkin and/or paper towel to wipe her mouth. 4. [Cross refer to W362]. The pharmacy failed to ensure drug regimen reviews were conducted at least quarterly for Clients #1, #2, #3, #4, #5, #6, # 7, and #8.	W 120	A meeting was held on 3/13/07 with the day program to address client #6's ability to wipe her mouth. NCC will informally reinforce client #6 ability to wipe her mouth. 4. The pharmacy had completed a pharmacy review on November 20, 2006. The pharmacy changed their tracking process.	2/12/07
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.	W 122		

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W 122	Continued From page 6 This CONDITION is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure each clients clothing was the appropriate size (See W137); failed to establish and/or implement policies that ensure the maintenance of each client's health and safety (See W149); failed to notify the designated administrator and other officials were immediately informed of allegations of abuse (See W153); failed to thoroughly investigate incidents of abuse (See W154); and failed to report the results of the investigation within five working days (See W156). The effects of these systemic practices results in the failure of the facility to protect its clients and to ensure their general safety and well being.	W 122		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure each client was encouraged to exercise their rights, for eight of the eight clients (Clients #1, #2, #3, #4, #5, #6, #7 and #8) included in the sample. The findings include:	W 125	HRC committee has reviewed policy for lock door policy for each individual affected.	3/15/07

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W 125	Continued From page 7 1. The facility failed to ensure the clients had free access/exit from their home. Observations conducted throughout the survey revealed the facility was locked and individual could neither enter or exit the facility without a key. Further observation and interview revealed that none of the clients in the sample had a key to the facility. Interview with the Program Manager on February 8, 2007 revealed the facility remained locked because there were clients living in the facility that were known to abscond. Additionally, the Program Manager revealed the doors remained locked as a means of safety to keep unwanted people from entering the facility. Interview with the Director of Quality Improvement on February 9, 2007 revealed that the front doors to the residential facility usually remained open during business hours however, at during the survey the doors were locked.	W 125	1. The Human Rights Committee reviewed the policy for use of the magnetic lock system on 3/15/07. See W104 #3	3/15/07
W 137	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure each clients clothing was the appropriate size, for one of the eight clients (Client # 4) included in the sample. The finding includes: Observation at Client #4's day program on February 7, 2007 at 11:56 AM revealed the client	W 137	A clothing inventory was completed on 3/15/07 Some new clothing will be purchased within the next 7 days. All non-fitting clothing will be removed by 3/21/07 and client #4 will be receiving some new clothing within the next 7 days.	3/21/07

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W 137	Continued From page 8 seated in the music room. The client was wearing black faded jeans with a belt, a green turtleneck, and black shoes. At 12:03 PM, the client was asked to go to the restroom to wash his hands prior to lunch. The client stood up and his pants were observed below his waist and his green underwear was exposed in the back. As the client walked to the restroom, the client was observed to hold onto the waist of his pants. Additional observation of the client ' s pants revealed the pant legs of the pants were long and very large. Interview with the Residential Counselor on February 6, 2007 revealed that he verbally prompts Client #4 to pull up his pants several times throughout his shift. Interview with the Qualified Mental Retardation Professional (QMRP) on February 9, 2007 revealed that she shops for all of Client #4's clothing, however has some difficulty in selecting clothing for men. The QMRP further indicated that Client #4 is non-verbal and is not able to choose his own clothing. At the time of the survey, the facility failed to ensure Client #4's pants were well fitting and appropriately sized.	W 137	See W137 for additional information	
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensure the health and safety of eight of the eight clients (Clients #1, #2, #3, #4, #5, #6, #7, and #8)	W 149	1. The Supervisors and Program Director will ensure that the incident reports completed and signed in accordance with agency policy. This is effective immediately as of 3/15/07	3/15/07

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W 149	Continued From page 9 included in the sample. The findings include: 1. The facility failed to implement its "Incident Management Policy" as outlined. Review of unusual incident reports on February 6, 2007 beginning at 11:19 AM revealed there were twelve (12) injuries of unknown source, three (3) incidents of client to client abuse, causing injury, from July 6, 2006 through July 31, 2006. Further examination of the incident report forms revealed that there were areas requiring signature from the supervisor and Program Director after they had completed their review. Review of the facility's "Incident Management Policy" on February 6, 2007 revealed incidents were categorized into serious reportable and reportable incidents. The policy stipulated that both serious reportable and reportable incidents were to be reviewed by the Program Director. It documented, the " Program Director or designee will review/complete the Incident Report form within one workday of receipt of the form. " According to the federal regulations §483.420(d)(2),."The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures." Interview conducted with the Director of Quality Improvement on February 8, 2007, revealed the Residential Program Director was designated as the administrator who reviews unusual incidents involving the residential population. She,	W 149	2. The residential Program Managers are the administrators who reviews the unusual incidents for the residential population in their respective programs. The program will ensure that the incidents are reviewed in a timely manner. This will be evidenced by 3/12/07 There is no regulation that specifies that the CEO must be the administrator who reviews the incidents nor has the agency historically operationalize the function of the CEO in such a manner.	3/12/07

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W 149	Continued From page 10 however indicated that allegations of abuse, neglect and mistreatment are reported to the administrator, the Chief Executive Officer (CEO). Although the majority of the reports were signed by the RPD, there was no indication or documented evidence verifying that the administrator (CEO) had reviewed/signed all incidents/investigations, or that the CEO had designated the RPD to act as the administrator. At the time of the survey, the facility failed to develop and/or implement an incident management policy that was in compliance with the federal regulations. 2. The facility failed to implement and provide evidence of a reproducible system to investigate injuries of unknown origin. Review of unusual incident reports on February 6, 2007 beginning at 11:19 AM revealed there were 12 injuries of unknown source from July 6, 2006 through July 31, 2006. Further review of the incident reports revealed a possible origin of the injuries was documented on the face of the reports. The incident reports however did not indicate what measures were used to determine the possible origin of the clients' injuries. According to the "Incident Management Policy" in the section entitled "Injuries of Unknown Origin ", the policy presented steps to be taken by the facility to ascertain information regarding how an injury occurred. The policy documented, "For injuries of unknown origin that are minor in nature, i.e. require minor first aid and are suspicious based on the nature or circumstances of the injury, the functional and medical status of the individual, or the environment in which the individual has been placed a modified	W 149	The incidents of unknown origin are always investigated. The forms used for notes during an investigation of an injury of unknown origin has been revised and should help outline the measure used to determine the possible origin of a clients injury (see attachment) This was completed on 2/7/07. g gin n	2/7/07

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W 149	Continued From page 11 investigation format is used". At the time of the survey, the facility failed to provide evidence that the modified investigation format had been implemented. 3. The facility failed to implement its policy on the timely review of the Emergency Use of Restraints by the HRC for Clients #1 and #2. Interview and record review on February 8, 2007 at 10:37 AM revealed the incident manager revealed a Review of Emergency Restrictive Procedure Use form is completed after each physical and chemical restraint. The review of the policy on February 9, 2007 revealed that the Human Rights Committee (HRC) chairperson shall be notified of the incident by next business day. According to the agency's policy, the HRC shall meet once a month to review and evaluate all rights related issues, including the emergency use of restrictive techniques. a. A Restraint Report dated May 3, 2006 revealed at 2:00 PM Client #1 was placed in a one person two arm Mandt Restraint and also received prescribed Haldol 5 mg IM as emergency restraints on that date due to his physical aggression and failure to respond to repeated attempts to calm him. Interview with the QMRP and record review on February 9, 2007 indicated the incident manager completed the Review of Emergency Restrictive Procedure Use on May 16 , 2006. The review of the HRC Minutes/ Feedback Form revealed the Emergency Use of Restraint/rights Restriction (Physical and chemical restraint) was not reviewed until July 24, 2006. b. A Restraint Report dated June 16, 2006	W 149	The policy will be reviewed and modified if necessary 3/31/07 a. The agency will insure that the agency's policy complies with federal and local regulations. In the future the agency will comply with its policy. 3/31/07 b. See response to W 149; 3(a) 3. The agency's clinical staff notified the school on 3/13/07 in writing and asked the residential clinical team to notify QMRP's if clients are involved in any incidents or restraints upon notification. QMRP will contact schools Compliance Specialist to ensure that incidents or restraint reports are forwarded to HRC.	3/31/07 3/31/07 3/13/07

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W 149	Continued From page 12 revealed at 8:06 AM, Client #2 was placed in a " one man" restraint due to bolting from her classroom and running the hallway of the school and the stairwells. According to the report, the client exhibited physical aggression toward staff when they attempted to get her to return to the classroom. The review of the HRC Minutes/ Feedback Form revealed the Emergency Use of Restraint/rights Restriction (Physical and chemical restraint) was not reviewed until August 11, 2007. There was no evidence the facility ensured the HRC was notified of the emergency restraints on the next business day as specified by agency policy. 4. The facility failed to have a system for the immediate notification of the administrator. Interview was conducted with the Residential Program Director (RPD) on February 6, 2007 concerning who is the designated person who reviews unusual incident reports. The RPD indicated that he signs the unusual incident reports. The review of the unusual incident reports revealed they should have a signature confirming a Program Director/Manager Review to determine the status (open or closed) of the incident. The review of twelve incidents revealed three of the incidents had been reviewed more than 5 working days (seven) after the incident. Twelve of twelve incidents reviewed no evidence the administrator had been notified. 5. The facility failed to implement their policy on Disposal of Drugs as evidenced by: Observation of the evening medication pass on February 6, 2007 revealed that the Licensed	W 149	4. The incident reports have a section for the form that indicates who was notified. The agency will insure that this section is completed on future reports, effective 3/15/07. The Program Director/Manager reviews all incidents and is the administrator (by history and practice) who has always reviewed the incidents. #5 Nursisng Staff were instructed in "Back to Basics Pharmacy" inservice 3/8/07 and have reviewed the current medication policy periodic nursing meetings will continue as teaching opportunities to review policies/ best practice principles. (See Attachment#1 and #2)	3/15/07 3/8/07

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W 149	Continued From page 13 Practical Nurse (LPN) prepared approximately 12 milliliters of Colace liquid for Client #9. Further observation revealed that the LPN poured approximately 2 milliliters of the Colace liquid into a regular plastic lined trash can. Interview with the LPN revealed that Client #9 was to be administered only 10 milliliters of Colace liquid and that she had to discard the excess medication. Review of the policy on Disposal of Drugs revealed that wasted drugs shall be made by the nurse administering the medication in the Medical Waste red bag. There was no evidenced that the medication was discarded according to the facility's policy. 6. [Cross Refer to W338]. The facility failed to implement its policy entitled "Weights" that required that the nurse to evaluate the clients' health/medical condition and notify the Primary Care Physician (PCP) of the findings.	W 149	The current weights procedure has been reviewed. Pertinent information will be incorporated into a new policy entitled "Nursing Documentation in the medical record. This will be issued on or before 4/15/07 at which time the weights procedure will be discontinued.	4/15/07
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure all allegations of mistreatment, abuse, and injuries of unknown origin were immediately reported to the administrator and other officials in accordance with State law. The finding includes:	W 153	Allegations of mistreatment neglect and unknown origin are immediately reported to the Program Director/Manager, who has historically and as a practice, has been the administrator notified and it is usually indicated on the incident report itself.	

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W 153	Continued From page 14 1. The facility failed to ensure unusual incidents (injuries of unknown origin and client to client mistreatment) were reported to the administrator. Review of unusual incident reports on February 6, 2007 beginning at 11:19 AM revealed there were 12 injuries of unknown source, 2 episodes of one client biting another client, and 1 episode of one client pushing another client causing injury, from July 6, 2006 through July 31, 2006. Further examination of the incident report forms revealed that there were areas requiring signature from the supervisor and Program Director after they had completed their review. Interview with the Residential Program Manager indicated the usual procedure is to sign these forms after reviewing them. Review of the facility's "Incident Management Policy" on February 6, 2007 revealed incidents are categorized into serious reportable and reportable incidents. The policy stipulated that both serious reportable and reportable incidents are reviewed by the Program Director. It documented, the "Program Director or designee will review/complete the Incident Report form within one workday of receipt of the form." Interview conducted with the Director of Quality Improvement on February 8, 2007, revealed the administrator was the Chief Executive Officer, however the Residential Program Director was designated to conduct the initial review and sign the incidents. At the time of the survey, the facility failed to provide evidence that the administrator and/or other officials had been made aware of the aforementioned incidents	W 153	1. The agency will ensure that this practice is followed. In addition the incident reports are reviewed and signed by the Program Director/Manager. The Incident Management policy will be reviewed (modified if deemed necessary) to ensure it complies with federal and local regulations this will be completed by 3/21/07	3/21/07

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W 153	Continued From page 15 2. The facility failed to ensure each allegation of mistreatment,neglect or abuse was reported to the administrator in accordance with state law for example: The review of an unusual incident report dated November 7, 2006 revealed Client #11 alleged one of his classmates was making him perform oral sex and taking his money. Interview and record review on February 8, 2007 revealed the investigation was completed on November 15, 2006 and reviewed by the designated program manager on November 20, 2006. There was no evidence the administrator was notified of the incident. 3. Review of the Unusual Incident Management log book on February 6, 2007 starting at approximately 11:00 AM revealed that following injuries were not reported to the Department of Health (DOH) as evidenced below: a. On 1/27/07, Client #7 walked over to Client #6 and head butted her causing a cut over the upper left eye. b. On 9/3/06, during an episode of agitation., Client #11 bit Client #1 who was sitting beside him. c. On 1/29/07, Client #12 was found with a red mark the size of a tennis ball on his body. d. On 8/27/06, Client #13 was discovered with a hematoma (lump measuring about 1½ inches diameter) on his head while receiving medications e. On 9/10/06, Client #14 was discovered with	W 153	2. The Program Manager (Administrator) for the program where the incident occurred was notified on: when the Program Director/ Manager was notified, in effect the Administrator was notified. 3. (a-e) The program will coordinate with the Quality Improvement Department to ensure that the agency is compliant with all the reporting requirements mandated by federal and local regulations this will be effective as of 3/16/07.	3/16/07

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W 153	Continued From page 16 scratches under his left eye during a body check.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure allegations of abuse were thoroughly investigated. The finding includes: 1. Review of unusual incident reports on February 6, 2007 beginning at 11:19 AM revealed an incident dated September 19, 2006 involving Client #2. According to the incident report, the client alleged having unconsensual anal sex with male client. Additionally, the client complained of her "butt" hurting and there was evidence of a pink/brown substance coming from her anal area when the client wiped herself. The review of a nursing progress noted dated September 19, 2006 at 4:30 PM revealed Client #2 requested the nurse to observe pink/brown stains on toilet paper she had used. The client consented to an examination by the supervisory RN in the presence of the LPN. During the visual examination of the client's rectal area, no fissure, exudate or frank bleeding was noted. According to the progress note, the client stated her "butt" hurt but she was "ok" The client was sent to the emergency room for follow-up on the alleged non-consensual sexual activity with another client. The incident investigation which concluded on September 21, 2006 revealed the client refused to be evaluated at the ER. Although the results of	W 154	Client #2 was seen at GYN clinic at Washington Hospital Center on 10/24/06. The need for further examination was ruled out by treating physicians. (See attachment for additional information)	3/16/07

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W 154	Continued From page 17 the investigation could not substantiate sexual abuse, the facility failed to address the origin of the pink/brown substance. 2. Cross Refer to W153. Review of unusual incident reports on February 6, 2007 beginning at 11:19 AM revealed there were 12 injuries of unknown source, 2 episodes of one client biting another client, and 1 episode of one client pushing another client causing injury, from July 6, 2006 through July 31, 2006. Further review of the reports revealed there were incidents revealed writing on the face of the reports documenting the possible nature of the injuries. There was no information however, documenting how the investigation was conducted, who was interviewed, and how a conclusion was made based on the investigation. At the time of the survey, the facility failed to provide evidence that the aforementioned incidents were thoroughly investigated. (See also W149)	W 154	See responses to W 149 and W 153	
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator or designated representative with in five working days of the incident, for .... The findings include: The facility failed to have a system for the timely	W 156	See responses to W 149 and W 153	

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W 156	Continued From page 18 notification of the administrator. a. [Cross Refer to W153] Interview was conducted with the Residential Program Director (RPD) on February 6, 2007 indicated he was the designated person to review and sign unusual incident reports and investigations. The review of the unusual incident reports revealed they should have a signature confirming a Program Director/ Manager Review to determine the status (open or closed) of the incident. b. The review of three of twelve incidents revealed they had been reviewed by the administrator more than 5 working days (seven) after the incident. For example, an allegation of psychological was made on September 112, 2006 . The investigation was completed on September 20, 2006 and signed by the Residential Program Manager on September 21, 2006. c. Twelve of twelve incidents reviewed February 7 , 2007 revealed no evidence the administrator had been notified of the results of the investigation. For example, Client #2 made an allegation of Sexual Abuse and Staff Neglect on September 19, 2006. Interview with the Director of Quality Improvement (QI) on February 8, 2007 confirmed that the RPD signs the unusual incident reports and investigations for the residential population. She, however indicated that allegations of abuse, neglect and mistreatment are reported to the administrator, the Chief Executive Officer (CEO). The results of this investigation failed to substantiate the allegations of sexual abuse and staff neglect. At the time of the survey, however the facility failed to provide evidence that the results of investigations were reported to the administrator	W 156		

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W 156	Continued From page 19 or designated representative within five working days of the incidents.	W 156		
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview and record review the facility failed that each client's active treatment program was coordinated, integrated and monitored by the Qualified Mental Retardation Professional (QMRP). The findings include: 1. The QMRP failed to ensure that Client #4 received the appropriate clothing size in accordance with his needs. [See W137] 2. The QMRP failed to ensure that staff receive training on Client #4's feeding protocol. [See W 189] 4.[Cross refer to W193]. The QMRP failed to ensure direct care staff implemented Client #7's Behavioral Support Plan (BSP). 5. The QMRP failed to ensure Client #2 had a transition plan that documented areas of concern and necessary supports needed by the client prior to her transition to a least restrictive environment. (See W202) 6. The QMRP failed to ensure each client's comprehensive functional assessment identified	W 159	See W137 pg 8 1. See responses to W 137 Pg 8 2. QMRP will add adaptive skills goal that address eating w/ utensils on 3/20/07. Staff will also be trained on implementation of this goal. 4. Staff will be retrained on Client # 7's BSP by 3/20/07	3/20/07 3/20/07

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W 159	Continued From page 20 specific the specific limitations that justified the client's food being locked. (See W214) 7. The QMRP failed to ensure Client #5's Behavior Support Plan (BSP) had been updated. Interview with staff and review of Client #5's record on February 8, 2007 revealed the client had a residential BSP. Review of the BSP that was maintained in his habilitation records revealed the plan was dated September 7, 2005. Closer examination of the plan revealed it was neither signed nor dated by the licensed psychologist. Further interview with staff on February 8, 2007 revealed that there was another copy of a BSP for Client #5 dated February 6, 2006. Additional review of this plan revealed that it too had neither been signed nor dated by a licensed psychologist. At the time of the survey, the QMRP failed to ensure Client #5 had a current copy of his BSP. 8. The QMRP failed to ensure clients were provided with opportunities for choice and self-management. (See W247) 9. The QMRP failed to ensure that Clients #1, #2 and #4 was taught to use and make informed choices about his eyeglasses and failed to closely monitor the condition of wheelchairs for Clients #5, #9, and #10. [See W436] 10. The QMRP failed to coordinate timely with the nutritionist regarding Client #7's weight loss.	W 159	5. QMRP will write a transitional plan for client #2 by 3/16/07 6. The facility could not identify a client to which this citation refers. Spoke to Lead supervisor on 3/15/07 and advised to omit. 7. See response to W 114 #1 8. Clinical team met with NCC Dietician on 3/13/07 and she ensured the team that the clients will receive appropriate metal silverware. Condiments will be made available to clients at meal times. 9. QMRP will make addendums to client #1's and 4's ISPs. An adaptive skills goal will be implemented on 3/21/07. Staff will be trained on this goal by 3/21/07. Client # 2's eye exam on 3/14/07 revealed tha she did not require eyeglasses (see attachment) Clients # 5, 9, and 10; wheelchairs were serviced on: Client #5 on 3/31/07 Client # 9 on 3/2/07 Client # 10 on 3/9/07 (see attachment for receipts) chairs continue to be monitored by nursing staff.	3/16/07 3/13/07 3/21/07 3/14/07
W 189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively,	W 189	10. IDT meeting was held to discuss client #7 weight loss with Nutritionist on 2/8/07. (see attachment for mtg notes)	2/8/07

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W 189	Continued From page 21 efficiently, and competently. This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to provide each employee with initial and continuing training that enables the employee to perform his or her duties, effectively, efficiently, and competently for two of eight clients included in the sample. (Clients #1 and #4) The finding includes: 1. Observations of the dinner meal conducted on February 6, 2007 at 5:39 PM revealed Client #4 eating Spanish rice and string beans from a Styrofoam plate with his hands while the Residential Counselor beside him. Further observations revealed Client #4 eating a fruit cup with his hands as well. Interview with the Residential Counselor on the same day at approximately 5:47 PM revealed that Client #4 feeds himself independently. Interview with the Qualified Mental Retardation Professional (QMRP) on February 9, 2007 revealed that staff had not been trained on Client #4's feeding protocol. There was no evidence staff attempted to redirect the client to use his eating utensils. 2. [Cross Refer to W149]. The facility failed to provide evidence that staff were effectively trained on the facility's "Incident Management Policy " 3. [Cross Refer to W193, 2]. The facility failed to	W 189	1. Staff will be trained on client's meal protocol by: 2. Staff will receive training on Incident management protocol by: 3. Staff will receive training on wellness policy Also see response to W 159 #2	3/20/07 4/15/07 4/15/07

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W 189	Continued From page 22 ensure staff was effectively trained on the implementation of Client #1's therapeutic diet. According to a written statement by the QMRP dated November 20, 2006, a staff escorted the client to the vending machine and the client purchased sweets. The food was later taken from the client by other staff after the client returned to the residential facility. The client was told the food was not good for him and staff would ask the dietitian if the client could have some of the food he purchased, since the client is on a special diet. The client became upset because the food was taken away and became aggressive . Interview with the nutritionist on February 7, 2007 indicated the staff did not require much training on the therapeutic diets because the food for the clients requiring special diets was preportioned on plates in the kitchen before bringing it to the dining room. There was no evidence the staff was effectively trained on foods allowed on the client's therapeutic diet (1800 calorie, low cholesterol).	W 189	QMRP will retrain staff on client #1 1800 calorie diet by 3/20/07. In addition staff will be trained on NCC's wellness policy annually.	3/20/07
W 193	483.430(e)(3) STAFF TRAINING PROGRAM Staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage the inappropriate behavior of clients. This STANDARD is not met as evidenced by: Based on observations, staff interviews and the review of records, the facility staff failed to demonstrate competency in the implementation of the Behavior Support Plans (BSP) for two of eight clients in the sample. (Client #1 and #7) The findings include:	W 193		

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W 193	Continued From page 23 1. Observation on February 07, 2007, at approximately 3:17 PM revealed that the Qualified Mental Retardation Professional (QMRP) verbally prompted and signed to Client #7 to point to what she wanted from several picture symbol cards. Client #7 was observed to point to a picture of a food item. The client than got up from her chair and walked over to a table and picked up a small four ounce container of orange juice. Staff took the orange juice container from the client, stating that she was allergic to orange juice. Client #7, returned to her chair and head butted another client that was sitting on a sofa next to her chair. The client that was assaulted and several other clients in the vicinity were removed from the area. Further observation revealed that the staff did not attempt to engage the client in any further activities. Interview with the staff revealed that they had been trained on the Client #7 ' s Behavior Support Plan (BSP). Review of the BSP dated October 13, 2005(expiration date January, 2008) revealed that the client has targeted behaviors that included physical aggression(head butting, hitting, kicking), self-injurious behavior, oppositional behavior, hyperactivity, short attention span, poor concentration, distractibility, low frustration tolerance, poor impulse control, fecal smearing, and temper tantrums. Further review revealed that if the client becomes physically aggressive towards others she should be directed to complete program activities after any behavior in order to avoid inappropriate reinforcement of target behavior. There was no evidence that staff demonstrated competency in the implementation of Client #7 ' s BSP. 2. The facility failed to ensure staff were effectively trained on the management of Client # 1's Maladaptive behaviors.	W 193	1. Staff will be retrained on program. QMRP will continue to monitor and coach staff to engage clients and implement behavior management programs. Also see response to W 159 #4	3/20/07

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W 193	Continued From page 24 Interview with staff on February 6, 2007 revealed that Client #1 has a behavior support plan which includes interventions for aggression (verbal and physical), bolting, and non-compliance. According to the agency's investigation of a serious reportable incident, Client #1 exhibited physically aggressive behavior on November 20, 2006 at 6: 00 PM which resulted in several Mandt Restraints over a period of approximately 45 minutes and a telephone call for emergency assistance (911). The police arrived and place handcuffs on the client when he became aggressive toward them. The client was then taken from the ICFMR to a hospital where he remained for treatment. He was readmitted to the facility on November 27, 2006 in stable condition. Record verification on February 9, 2007 revealed Client #1 had a behavior support plan which addresses bolting, noncompliance, verbal aggression,aggressive behavior, regressive behavior and inappropriate sexual behavior. The functional analysis indicated that when unit staff fail to notice and identify the warning signs of his irritability or anger, his irritability can quickly escalate to aggression and bolting. Further, the client's limited coping skills and being upset when he is angry, which may often lead him to engage in physical aggression against staff and peers, property destruction and or/or bolting. The BSP includes a proactive strategy which states "When staff notices that [Client #1] is upset or agitated about something, after two attempts to help him deal with what is upsetting him, staff should always give [Client #1] a break from the situation. Staff should refrain from continuing to talk to [Client #1] about the situation when he is noticeably upset and allow him to calm down in	W 193	2. Staff will be trained on clients #1 BSP on 3/16/07 (see attachment for signature sheet).	3/16/07

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W 193	Continued From page 25 his room or away from the group. Staff should refrain from attempts to solve the problem until [Client #1] is visibly calm. Staff should also refrain from getting into an argument with [Client #1] when he is visibly upset/angry." A review of the facility's internal incident investigation was conducted on December 19, 2006 by the Incident Review Committee (IRC). The IRC review concluded that on November 20, 2006, a staff allowed Client #1 access to a vending machine to purchase several items that were not permitted on his 1800 calorie, Low Cholesterol Diet for control weight. Another staff who noted that the client had the food items not allowed on his diet, took them from the client which lead to his behavioral outburst. The behavioral episode led to the Mandt restraint, the police being called and the client being hospitalized for six days. The IRC recommended training for staff to include avoiding power struggles and also to discuss taking the personal items the client was allowed to purchase. At the time of the incident, there was no evidence each staff was effectively trained on the proactive strategies and interventions included in Client #1 's behavior support plan to address his maladaptive behavior.	W 193	See W193 Pg 25	
W 202	483.440(b)(4)(ii) ADMISSIONS, TRANSFERS, DISCHARGE If a client is to be either transferred or discharged, the facility must provide a reasonable time to prepare the client and his or her parents or guardian for the transfer or discharge (except in emergencies). This STANDARD is not met as evidenced by:	W 202	See W159 #5	

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W 202	Continued From page 26 Based on interview and record review, the facility failed to provide evidence that clients were given a reasonable amount of time to prepare for transfer or discharge from the facility, for one of the eight clients (Client #2) included in the sample The finding includes: Interview with Client #2 on February 7, 2007 at 3: 51 PM revealed the client went to see her new apartment on February 6, 2007. The client indicated that her new apartment was located near a zoo. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on February 9, 2007 to ascertain information about whether or not a transition plan had been developed that identified Client #2's needed supports and/or goals to be attained prior to her transitioning out of the facility. The QMRP revealed that the client had just signed a form that indicated her acceptance of the new location and request to be transferred. At the time survey, however, the facility failed to provide evidence that a transition plan had been developed for Client #2..	W 202	A traditional plan was developed. (See attachment). Also see response to W159 #5	
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them.	W 242	QMRP will meet with the IDT team to discuss the concern by the surveyor. However, the client has demonstrated that she can perform this task with prompts and gestures. See W 120 Pg 6 #2	

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W 242	Continued From page 27 This STANDARD is not met as evidenced by: Based on observations, interview, and record review, the facility failed to ensure needed personal hygiene skill training was provided to one of eight clients in the sample. (Client #6i). The finding includes: [Cross refer to W120]. The facility failed to ensure that a program was developed to train Client #6 to wipe her mouth using appropriate materials (i.e. paper towels, napkins, tissue).	W 242		
W 247	483.440(c)(6)(vi) INDIVIDUAL PROGRAM PLAN The individual program plan must include opportunities for client choice and self-management. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure clients were encouraged to make choices and increase self-management in their environment to the extent of their capability for eight of the eight clients (Clients #1, #2, #3, #4, #5, #6, #7 and #8) included in the sample. The findings include: 1. The facility failed to ensure clients were given the opportunity to make choices. a. Observation on the evening meal on February 7, 2007 beginning at 5:12 PM revealed staff serving the clients their meal (stewed beef with rice, green beans, flavored milk, fruit cocktail and water. There were no condiments, such as salt or pepper offered or present on the table for the evening meal. Additionally, staff was observed to	W 247	See W120 pg. 6 #2 a. QMRP conducted training on family-style dining protocol on 3/14/07. Additional training will occur on 3/21/07. Training will be scheduled annually	3/14/07

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W 247	Continued From page 28 scoop Client #2's food from a bowl, and place it on her plate. At the time of the survey, the facility failed to ensure clients were provided the opportunity to make choices during mealtimes. b. During dinner observation on February 06, 2007, Clients #1, #3, #7 and #8 were observed eating the food that had been served on their plates. Further observation revealed that there were no condiments provided on the table or offered during the dinner meal. Interview with staff revealed that this was a daily practice and that condiments were not provided on the table or offered during mealtime. There was no evidence that condiments had been provided for the clients. 2. The facility failed to offer a choice of food at snack time for Client #7. Observation on February 07, 2007, at approximately 3:17 PM revealed that the Qualified Mental Retardation Professional (QMRP) verbally prompted and signed to Client #7 to point to what she wanted from several picture symbol cards. Client #7 was observed to point to a picture of a food item. The client than got up from her chair and walked over to a table and picked up a small four ounce container of orange juice. Staff took the orange juice container from the client, stating that she was allergic to orange juice. There was no evidence that a choice of an appropriate food was provided to the client from which to select. 3. The facility failed to offer clients a choice of different types of silverware. Observation of the dinner meal on February 6, 2007, Clients # 3 was observed to eat his meal with a plastic fork. The client was observed using his fingers to push the food on the fork and to prevent from falling to the plate. Additionally other	W 247	b. See W 189 pg 21 #8 2. Client # 7's primary care physician ruled out allergic reaction to orange juice see attached nursing note on 2/8/07. When allergies and or/dietary restrictions are noted alternative choices are provided. See W 189 pg 21 #8 3. Food services will make proper utensil available during meals. See W 159 #8	3/13/07 3/14/07 3/13/07

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W 247	Continued From page 29 clients in the sample were observed to eat their meal using plasticware during the same during dinner. Interview with the nutritionist on February 7, 2007 at 6:21 PM revealed the clients should be provided metal silverware with which to eat their meals. There was no evidence the clients were offered a choice of eating utensils at mealtime.	W 247	3. See W 159 pg 21 #8	
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observations, interviews, and record verification, the facility failed to demonstrate that one out of eight clients in the sample are actively and consistently encouraged to engage in learning opportunities to maintain or enhance their skill levels for three of fifteen clients in the survey (Clients #7, #9, and #10). The findings include: 1. The facility staff failed to provide active treatment for Client #7 by implementing her Behavior Support Plan's (BSP) as written. Observation on February 07, 2007, at approximately 3:17 PM revealed that the Qualified Mental Retardation Professional (QMRP) verbally prompted and signed to Client #7 to point to what	W 249	1. Staff was retrained on client #7's BSP plan on 3/15/07. See W 159 pg 20 #4	3/15/07

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W 249	Continued From page 30 she wanted from several picture symbol cards. Client #7 was observed to point to a picture of a food item. The client than got up from her chair and walked over to a table and picked up a small four ounce container of orange juice. Staff took the orange juice container from the client, stating that she was allergic to orange juice. Client #7, returned to her chair and head butted another client that was sitting on a sofa next to her chair. The client that was assaulted and several other clients in the vicinity were removed from the area. Further observation revealed that the staff did not attempt to engage the client in any further activities. Interview with the staff revealed that they had been trained on the Client #7 ' s Behavior Support Plan (BSP). Review of the BSP dated October 13, 2005(expiration date January, 2008) revealed that the client has targeted behaviors that included physical aggression(head butting, hitting, kicking), self-injurious behavior, oppositional behavior, hyperactivity, short attention span, poor concentration, distractibility, low frustration tolerance, poor impulse control, fecal smearing, and temper tantrums. Further review revealed that if the client becomes physically aggressive towards others she should be directed to complete program activities after any behavior in order to avoid inappropriate reinforcement of target behavior. There was no evidence that staff implemented Client #7's BSP as written.. 2. The facility failed to ensure Clients #9 was provided the opportunity to consistently participate in his training program to develop their self-help skills in eating. On February 7, 2007, staff was observed to feed	W 249	1. Staff was retrained on client #7's Behavior Support Plan on 3/15/07 See W159 #4	3/15/07

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W 249	Continued From page 31 Client #9 his breakfast from a sectioned plate using a built-up handle spoon. Interview with staff indicated the client should participate by allowing hand-over-hand assistance from staff. According to Client #9's individual program plan (IPP) dated October 24, 2006, he has a goal to improve his eating skills. The objective states "When given an adaptive spoon and a plate of food, [Client #9] will pick up the spoon, with assistance from staff and feed himself with 50% independence for 8 of 10 trials." A second meal observation on February 9, 2007 at breakfast revealed staff feeding the client. Interview with the staff indicated the client participates in the feeding process when more time is available and he does not have to leave for his school which is located away from the facility. At the time of the observation, there was no evidence client was encouraged to participate in his training objective designed to improve his eating skills. 3. On February 7, 2007, staff was observed to feed Client #10 his a pureed breakfast using a built-up handle spoon. Further observation and interview with staff feeding the client revealed the client needs assistance to consume both pureed and liquid foods. Interview with staff and the review of the client's meal protocol revealed the all liquids other than water were thickened to a honey consistency. The client was observed to cough several times after finishing his meal. A second meal observation on February 9, 2007 at breakfast revealed a different staff feeding the client in the same manner. Interview with the staff indicated the client has a formal program to participate in a feeding program in the evenings, however when there is enough time at other meals he is provided an opportunity help feed himself. According to Client #10's individual	W 249	2. QMRP will retrain staff on client #9 feeding protocol by 3/20/07 3. QMRP will retrain staff on client # 10's feeding protocol by 3/20/07 (see attached training sign in sheet)	3/20/07 3/20/07

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W 249	Continued From page 32 program plan (IPP) dated December 6, 2006, he has a goal to learn to use an adaptive spoon and to independently feed himself. The objective states "When provided with the appropriate materials, [Client #10] will scoop food using an adaptive spoon and feed himself with 25% independence for two consecutive months by December 5, 2007. During the morning observations on the aforementioned dates, there was no evidence the client was provided opportunities to participate in his feeding program to improve his self- help skill in eating.	W 249	see W249 # 3 pg. 32	3/20/07
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately monitor Client #10's s progress in his Individual Program Plan (IPP) participation in hand over hand eating from an adaptive spoon. The finding includes: On February 7, 2007, staff was observed to feed Client #10 a pureed breakfast using a built-up handle spoon. Further observation and interview with staff feeding the client revealed the client needs assistance to consume both pureed and liquid foods. Interview with staff and the review of the client's meal protocol revealed the all liquids other than water were thickened to a honey consistency. The client was observed to cough	W 252	QMRP will retrain staff on data collection as it relates to this program by 3/20/07.	3/20/07

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W 252	Continued From page 33 several times after finishing his meal. A second meal observation on February 9, 2007 at breakfast revealed a different staff feeding the client in the same manner. Interview with the staff indicated the client has a formal program to participate in a feeding program using hand over hand assistance in the evenings, however the program was implemented at other meals if there was enough time. According to Client #10's individual program plan (IPP) dated December 6, 2006, he has a goal to learn to use an adaptive spoon and to independently feed himself. The objective states "When provided with the appropriate materials, [Client #10] will scoop food using an adaptive spoon and feed himself with 25% independence for two consecutive months by December 5, 2007 . The review of the strategy for implementing Client #10's feeding program revealed, "If the client refuses to scoop his food , provide with hand over hand assistance .... During each meal evaluate only the first 10 scoops .... If [client refuses to participate in the program and staff attempts to get him to participate have failed after 5 minutes, staff should feed him." According to the schedule, the program should be implemented daily at 5:30 PM for thirty minutes, however the data should be recorded on Monday through Friday only. Staff should document the level of assistance required to get the client to consume each scoop of food until 10 scoops have been consumed. The review of program data for January 2007 indicated the client required hand-over-hand assistance on 14 of 23 days. On the other 8 of 23 days, the record failed to document any level of performance in the eating program.	W 252	See W 252 on pg 33	3/20/07

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W 252	Continued From page 34 There was no evidence that program data was documented at the frequency required by the objective to accurately measure the client's performance.	W 252	See W252 pg. 33, 34	3/20/07
W 259	483.440(f)(2) PROGRAM MONITORING & CHANGE At least annually, the comprehensive functional assessment of each client must be reviewed by the interdisciplinary team for relevancy and updated as needed. This STANDARD is not met as evidenced by: Based on observation, interviews, and record verification, the facility failed to ensure the comprehensive functional assessment was reviewed and updated to address the specific behavioral management needs for one of eight clients in the sample. (Client #8) The finding includes: On February 6, 2007, Client #8 was observed playing a game of basketball with staff and two other clients. Further observation revealed that the client became angry when the basketball was not passed to him immediately. Staff verbally re-directed the client and he complied. Interview with the Qualified Mental Retardation Professional (QMRP) revealed that Client #8 has a Behavior Support Plan's (BSP), however the plan was not current. Record verification revealed that Client # 8's last BSP expired on June 7, 2006. Further record verification revealed that the QMRP had notified the psychologist in writing regarding the expired BSP. There was no documented evidence that the client had a current BSP.	W 259	NCC Psychologist completed current BSP for client # 8 and trained staff on the BSP 3-9-07 (see attachment)	3/9/07
W 262	483.440(f)(3)(i) PROGRAM MONITORING & CHANGE	W 262		

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W 262	Continued From page 35 The committee should review, approve, and monitor individual programs designed to manage inappropriate behavior and other programs that, in the opinion of the committee, involve risks to client protection and rights. This STANDARD is not met as evidenced by: The facility failed to ensure the Human Rights Committee (HRC) conducted a timely review of the Emergency Use of Restraint for Clients #1. The finding includes: According to an unusual incident report dated May 3, 2006 at 2:00 PM, Client #1 became agitated, non-compliant and began destroying school property. After the client's failure to respond to staff efforts to calm him, the client was placed in a one person two arm Mandt Restraint for approximately four minutes, but continued to be physically and verbally aggressive. The client's psychologist, nurse and the PCP was notified. Record review revealed a physician's order dated May 3, 2006 for Haldol 5 mg IM. According to a nursing progress on the same date, Haldol 5 mg IM was administered at 2:20 PM. Interview and record review on February 9, 2007 revealed the incident manager completed the Review of Emergency Restrictive Procedure Use on May 16, 2006. The review of the HRC Minutes /Feedback Form indicated the Emergency Use of Restraint/rights Restriction (Physical and chemical restraint) was not reviewed by the HRC chairperson until July 24, 2006. According to the Emergency Guidelines and Notifications in the Restraint Report, the HRC Chair shall be notified	W 262	See W149 #3 Pg 12	

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W 262	Continued From page 36 on the next business day of the emergency restraint. There was no evidence a timely review of restrictive techniques used on Client #1.	W 262		
W 264	483.440(f)(3)(iii) PROGRAM MONITORING & CHANGE The committee should review, monitor and make suggestions to the facility about its practices and programs as they relate to drug usage, physical restraints, time-out rooms, application of painful or noxious stimuli, control of inappropriate behavior, protection of client rights and funds, and any other areas that the committee believes need to be addressed. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to review, approve or make suggestions regarding the use of the locks on the main exit doors to the residential facility. The finding includes: [Cross refer to W125]. On February 6, 2007 at 7: 15 AM the main exit doors were observed to be locked. Although interview with several staff during the survey, indicated that at times the door are not locked during the day, the doors were observed to remain locked throughout the survey. Interview with the Residential Program Director (RPD) revealed that the locks were installed to prevent clients who have targeted behavior of abscondence from attempting to exit the facility. Additionally, the RPD indicated that this practice prevents unauthorized individuals from entering	W 264	See W104 #3	3/15/07

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W 264	Continued From page 37 the building. Further interview with the RPD and the Director of Quality Improvement (QI)and the record verification failed to provide evidence the facility's Human Rights Committee (HRC) had reviewed or made suggestions regarding the continuous use of the locks on the doors at the facility.	W 264	Cross reference W104 #3	
W 322	483.460(a)(3) PHYSICIAN SERVICES The facility must provide or obtain preventive and general medical care. This STANDARD is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to provide or obtain preventive and general care and failed to implement medical protocols for one of eight clients in the sample (Client #7). The findings include: 1. The Primary Care Physician failed to assess Client #7's weight loss timely. The facility's nursing staff failed to notify the Primary Care Physician (PCP) of Client #7's change in health status in January, 2007. Review of Client #7's weight chart revealed that the client weighed 193 pounds in December, 2006, and weighed 176 pounds in January, 2007, revealing that Client #7 had lost 17 pounds. Further review of the weight chart indicated that the client weighed 176 pounds in February 2007. The nursing staff acknowledged that the PCP was not made aware of the weight loss in a timely manner . Review of a nursing progress note dated February 6, 2007, revealed that the PCP was	W 322	1.The primary physicians progress note entry Of 2/8/07 reflects timely response to a weight loss that was desired and reported as typical for medication change to Geodon. (See attachment #3 A and B): Medical staff will follow their policy to inform the Nutritionist when a weight change of 5lbs or greater occurs during monthly weighing.	2/8/07

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W 322	Continued From page 38 made aware of the Client #7's weight loss. Review of the policy entitled "Weights" revealed that the PCP is to be notified of any weight gain or loss of a minimum of two pounds. There was no evidence that the PCP were made aware of the client's weight loss in January 2007 until February 2007. There was no evidence the client's weight loss was addressed timely by the PCP. 2. The facility's medical services failed to obtain a follow-up ophthalmology appointment for Client # 7 as evidenced by: Review of the ophthalmology consult dated November 8, 2005 revealed that a follow-up examination was recommended for Client #7 in one year. Further review revealed that the referring physician indicated that the eye examination was limited and that the client had mild myopia. Interview and record review revealed that the client did not go to back to the ophthalmologist as recommended. 3. The facility's medical services failed to obtain the results of Client #7's pelvic and abdomen examination that also included a breast and digital examination performed on February 6, 2006. The review of Client #7's consultation report dated February 6, 2007 on February 8, 2007 revealed Client #7 had a pelvic and abdomen examination. Further review of the client's clinical record revealed the results of the tests were not available. Interview with the nurse on February 9, 2007 revealed that the results of the tests could not be located. There was no evidence the facility ensured that the results of all medical tests were obtained and maintained in the client's record.	W 322	2. Client #7 participated in an Ophthalmalogy appointment on 3/13/07 (see attachment) The medical appointment diary will be correctly utilized to ensure that appointments will be made in a timely manner. 3. The medical appointment diary was amended to include a prompt for the date on which additional labs or reports from a medical appointment were obtained. (see medical attachment)	3/13/07

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W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two clients in the survey. (Clients #7 and #9) The findings include: 1. The facility's nursing services failed to inform the PCP of Client #7's weight loss. Review of Client #7's weight chart revealed that the client weighed 193 pounds in December, 2006, and weighed 176 pounds in January, 2007, revealing that Client #7 had lost 17 pounds. Further review of the weight chart indicated that the client weighed 176 pounds in February, 2007. The nursing staff acknowledged that the PCP was not made aware of the weight loss in a timely manner. Review of a nursing progress note dated February 6, 2007, revealed that the PCP was made aware of the Client #7's weight loss. Review of the policy entitled "Weights" revealed that the PCP is to be notified of any weight gain or loss of a minimum of two pounds. There was no evidence that the PCP were made aware of the client's weight loss in January 2007. 2. The facility's nursing services failed ensure that each medication that was wasted was disposed of in accordance with the policy on "Disposal of Drugs" for Client #9. Observation of the evening medication pass on	W 331	Cross reference W 149 Page 13 (Attachment # 1 and 2) 1. Cross reference response to W 322 #1 page 38 attachment A and 3B, and W 338 pg 41.	

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W 331	Continued From page 40 February 6, 2007 revealed that the Licensed Practical Nurse (LPN) prepared approximately 12 milliliters of Colace liquid for Client #9. Further observation revealed that the LPN poured approximately 2 milliliters of the Colace liquid into a regular plastic lined trash can. Interview with the LPN revealed that Client #9 was to be administered only 10 milliliters of Colace liquid and that she had to discard the excess medication. Review of the policy on Disposal of Drugs revealed that wasted drugs shall be made by the nurse administering the medication in the Medical Waste red bag. There was no evidenced that the medication was discarded according to the facility's policy.	W 331	Cross reference W 149 Page 13 Attachment (#1 and 2)	3/8/07
W 338	483.460(c)(3)(v) NURSING SERVICES Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must result in any necessary action (including referral to a physician to address client health problems). This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility's nursing services failed to ensure timely follow-up on referrals in accordance with the needs of one of eight clients in the sample. (Client #7) The finding includes: The facility's nursing services failed to implement the facility's policy and procedures entitled " Weights" that required that the nurse to evaluate the clients' health/medical condition and notify the Primary Care Physician (PCP) of the findings. Record review revealed that the nursing staff	W 338		

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W 338	Continued From page 41 failed to notify the PCP of Client #7's change in weight as evidenced by: Review of Client #7's weight chart revealed that the client weighed 193 pounds in December, 2006, and weighed 176 pounds in January, 2007, revealing that Client #7 had lost 17 pounds. Further review of the weight chart indicated that the client weighed 176 pounds in February, 2007. The nursing staff acknowledged that the PCP was not made aware of the weight loss in a timely manner. Review of a nursing progress note dated February 6, 2007, revealed that the PCP was made aware of the Client #7's weight loss. Review of the policy entitled "Weights" revealed that the PCP is to be notified of any weight gain or loss of a minimum of two pounds. There was no evidence that the PCP were made aware of the client's weight loss in January 2007.	W 338	Cross reference W 322 page 38 and W331 page 40.	2/8/07
W 362	483.460(j)(1) DRUG REGIMEN REVIEW A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record, the facility failed to ensure that the pharmacist reviewed the drug regimens quarterly for eight of eight clients in the sample. (Clients #1, #2, #3, #4, #5,#6, #7 and #8) The findings include: Interview with the supervisory RN on February 8, 2007 revealed the pharmacist reviews the clients' prescribed medications quarterly. The review of the Drug Regimen Review forms in the clients'	W 362	Cross reference W 322 pg 38and W 331 pg 40	

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W 362	Continued From page 42 records indicated the pharmacist reviews of the medications for Clients #1, #2, #3, #4, #5, #6, #7 and #8 were conducted on August 9, 2006. The review of the agency's Medication Policy revealed a record of each resident's drug regimen review shall be kept in the resident's medical chart. There was no evidence the clients' drug regimens were reviewed at least quarterly.	W 362	Pharmacy reviews were conducted on 11/20/06. Format for pharmacist documentation changed since merger with Omnicare see attachment 5a and 5b.	11/20/06
W 365	483.460(j)(4) DRUG REGIMEN REVIEW An individual medication administration record must be maintained for each client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain medication administration records (MAR) to documenting the administration of medications for one of the eight clients in the sample (Client #1). The finding includes: The facility's nursing services failed to ensure that each medication administered to Client #1 was documented on the Medication Administration Record (MAR). The review of an unusual incident report dated May 3, 2006 revealed Client #1 received Haldol 5 mg for aggressive behavior. Interview with the nurse and the review of records on February 9, 2007 revealed a physician's order dated May 3, 2006 for Haldol 5 mg IM. According to a nursing progress on the same date, Haldol 5 mg IM was administered at 2:20 PM. Further interview with the nurse and the review May 2006 MAR revealed no evidence nursing services ensured the Haldol administer was documented on the	W 365	Nurses received training on "Back to Basics Pharmacy". On 3/8/07 and have reviewed current medication policy (see attachments #1&2)	3/8/07

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W 365	Continued From page 43 MAR in accordance with nursing best practices.	W 365		
W 429	483.470(e)(2)(i) HEATING AND VENTILATION The facility must maintain the temperature and humidity within a normal comfort range by heating, air conditioning or other means. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain the temperature within a normal comfort range in the residential facility. The findings include: The facility failed to maintain the temperature within a normal comfort range within a living unit for Clients #2, #6 and the hallways. a. Observation of Client #2 ' s bedroom on February 6, 2007 revealed the air temperature in the client's room felt cold. Cold air was coming from the crevices around the door frame and from around the frames of the windows upon inspection. Interview conducted with Client #2 on February 6, 2007 at 6:27 PM revealed the client slept with her sweater on. Record review revealed outdoor temperatures of 10 degrees Farenheit at 7:34 AM and 27 degrees Fahrenheit at 3:03 PM. on February 6, 2007 as measured by the National Weather Service for the metropolitan area. The Qualified Mental Retardation Professional (QMRP) was immediately informed of the condition of Client #2's bedroom and called for maintenance personnel. A maintenance person was shortly thereafter observed placing tape around the door to prevent the air from entering the room. It should be further noted that the maintenance	W 429	a. The facilities department will ensure that an equipment check and weather proofing occurs in fall prior to winter and spring prior to summer. Cross reference to W 104 #3 on pg 2.	2/9/07

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W 429	Continued From page 44 crew was observed on February 7 and 8, 2007 again attending to the cold air problem. At the time of the survey, the facility failed to ensure the temperature of Client #2's bedroom was maintained within a comfortable range at all times b. Observations of Client #2 and #6's living room conducted on February 6, 2007 at approximately 6:13 PM revealed that the room felt very cold. The ceiling tile was observed to have a hole approximately the size of a tennis ball where cold air was entering the room. On February 7, 2007, the hole was covered with tape to prevent the air from entering the room. c. On February 7, 2007 at 6:30 PM, the temperature was also noted to be cold in the hallway near the nursing station and near the clients' living unit. Observation of the exterior double doors leading into to the main hallway revealed cold air was entering the building around the doors. Record review revealed the outdoor temperature range on February 7, 2007 was 16 degrees Fahrenheit to 29 degrees Fahrenheit as measured by the National Weather Service for the metropolitan area. Observation and interview on February 8, 2007, revealed these exterior doors were repaired by the maintenance crew to prevent most of the air from entering. d. On February 9, 2007, the surveyors noted cold air entering the facility around the double entrance doors in the hallway adjacent to the dining rooms. This information was reported it to the Residential Program Manager (RPM). The outdoor temperatures on February 8, 2007 ranged from 17 degrees Fahrenheit to 29 degrees Fahrenheit as measured by the National	W 429	b. See W 429 item a. c. See W 429 item a. d. See W 429 item a.	2/9/07 2/9/07 2/9/07

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W 429	Continued From page 45 Weather Service for the metropolitan area. Interview with staff indicated the hallways were chilly because it was unusually cold outside. Further interview with the building maintenance supervisor however revealed the chilly temperatures in the building had not been reported to him. The doors were observed to have been repaired on February 9, 2007 to prevent the cold air from entering the building. There was no evidence the building temperatures had been maintained with a normal comfort range at all times.	W 429		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure wheelchairs were maintained in good repair for three clients in the survey (Clients #5, #9, and #10; failed to ensure one client (Client #1) was trained to care for his glasses; failed to ensure two clients (Client #2 and #4) was trained to wear their glasses; and failed to ensure adaptive feeding devices were used as approved by the interdisciplinary team for two clients (Clients #5 and #10). The findings include: 1. The facility failed to ensure a training program was implemented to encourage Client #2 and #4	W 436		

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W 436	Continued From page 46 to wear their eyeglasses. a. Evening observations conducted on February 6 , 2007 starting at 5:05 PM revealed Client #4 squinting while working with an electronic device. Interview with the Residential Counselor revealed that Client #4 wears glasses but exhibit behaviors if asked to wear them. Staff was observed at no time to encourage Client #4 to wear his eyeglasses. Interview with the Qualified Mental Retardation Professional (QMRP) on February 9, 2007 confirmed that Client #4 has glasses and revealed she should be encouraged to wear them everyday. Further interview with the QMRP revealed that Client #4 had not been taught to use and make informed decisions about his eyeglasses. The QMRP indicated that the residential staff had not been trained on the use of Client #4 ' s glasses. Record verification of Client #4's current physician's orders on February 8, 2007 at 10:20 AM revealed a treatment, "Glasses Everyday". There was no evidence that a system had been established to encourage Client #4 to wear his glasses as recommended. b. Observation of Client #2 on February 7, 2007 at 3:18 PM revealed the client was being assisted by staff to complete her program objective (learning how to read a clock). Interview with Client #2 on February 7, 2007 at 3:27 PM revealed the client had eyeglasses, but they were in her room. The client indicated that the glasses were used for reading. Continued interview with the client revealed the client did not take them to her day treatment program because she forgot	W 436	a. QMRP will implement a goal for client #4 to learn to care for his glasses by 3/20/07. The staff will be trained on client #4's goal by 3/20/07 (see attachment for sign-in sheet) Nurses will include glasses as a treatment on the MAR. Documentation of the MAR will occur daily. b. Cross reference W 159 #9	3/20/07 3/21/07

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W 436	Continued From page 47 them. Review of Client #2 ' s habilitation records on February 8, 2007 failed to provide evidence of a training program to assist the client with wearing her eyeglasses. At the time of the survey, the facility failed to provide evidence that Client #2 was being taught to wear her eyeglasses. 2. The facility failed to ensure that Client #1 was provided training to care for his eye glasses. On February 6, 2007, Client #1 was observed working on a written project for school. On February 7, 2007, Client #1 was observed solving math problems in his classroom with his face close to his paper. Interview with the client and staff revealed he wears glasses but he broke his new glasses. Staff showed the surveyor a pair of broken eyeglasses on February 9, 2007 which were waiting to be repaired and stated they belonged to Client #1. Further interview with the staff and the QMRP indicated client had broken several pairs of glasses. Interview with the QMRP indicated that attempts to train the client to care for his glasses had been unsuccessful. There was no evidence the client was currently involved in a training program to improve his skill in caring for his glasses. 3. The facility failed to ensure that the wheelchairs of Clients #5, #9 and #10 were maintained in good repair. a. Observation of Client #5 ' s wheelchair on February 6, 2007 revealed the left arm rest had tears in it that exposed the yellow padding material. At the time of the survey, the facility failed to ensure Client #5's wheelchair was	W 436	Client # 2 does not need to wear glasses see 159 #9 2. QMRP will implement a goal to teach client #1 to care for his glasses by 3/16/07. Staff will be trained on client #1's glasses protocol by 3/20/07. Psychologist will add "care for glasses" to client #1 privledge score card as a pro-social behavior 3. Client # 5 wheel chair was repaired 3-1-07 see w159 #9	3/14/07 3/16/07

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W 436	Continued From page 48 maintained in good repair. b. On February 7, 2007 Client #9 was observed using his wheelchair with the left foot rest missing . The foot rest was observed laying on the floor. Interview with staff indicated the footrest would not stay on the chair. Approximately, thirty minutes later a staff was observed wheeling the client from the unit with both foot rest on the chair. On February 8, 2007 the client was again observed in his wheelchair with the left footrest off the chair. There was no evidence Client #9's wheelchair was maintained in good repair. c. Client #10 was observed using his wheelchair without the left foot rest on February 8, 2007. Further observation of the chair revealed the part to which the footrest should be attached was missing from the chair. Interview with staff caring for the client indicated she was not aware of how the chair became in disrepair. According to the clients Individual Support Plan (ISP), the wheelchair should be cleaned and checked for needed repairs or adjustments weekly. There was no evidence the client wheelchair was maintained in good repair. 4. The facility failed to ensure that Client #10 was provided with an adaptive cup recommended to increase his fluid intake. During meal observations on during breakfast on February 7 and 9, 2007. Client #10 was offered regular consistency water from a spoon. Observation and interview, as well as the record verification revealed the client is prescribed to receive all other liquids thickened to a honey consistency. Record review revealed a Safe Swallow Guide dated March 20, 2006 which	W 436	Cross reference W159 #9 QMRP ordered adaptive cup on 3/12/07. Staff trained on his protocol on 3/12/07. (see sign in sheet attachment)	

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W 436	Continued From page 49 recommended to give liquids by spoon. The review of an Occupational Therapy progress noted dated January 4, 2007 revealed the client was tested on two adaptive devices to optimize his water intake (a large dropper and an adaptive cup with a control flow lid. the OT indicated that the client appeared to benefit from the adaptive cup with minimal spillage and the ability for the caretaker to control the flow of the liquid. Interview with the QMRP on February 9, 2007 indicated that she was aware of the recommendation for the adaptive cup and that additional follow-up was needed to obtain it. At the time of the survey, the cup was not available for the client's use.	W 436		
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observations and interview, the facility failed to ensure that procedures for prevention of infection control were implemented for one of eight clients included in the sample. (Client #6) The facility failed to ensure that Client #6 was provided with a napkin or paper towel to wipe her mouth instead of using a stained/soiled bib. Observation at Client #6 ' s day program February 7, 2007 at 11:06 AM, revealed the client in her treatment area seated on a chair located against a wall. The client was observed wearing a white bib that was stained. At approximately 11:13 AM, a female staff member asked Client #6 to wipe her mouth. The client did not respond. Shortly	W 455	Cross reference W112 #1	

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W 455	Continued From page 50 thereafter, a male staff member asked her to wipe her mouth and then prompted her by touching her left hand and directing her to wipe her mouth with the stained bib. Interview with the day program Support Staff Coordinator on the same day at approximately 11 :02 AM revealed that there was no program in place to assist Client #6 with wiping her mouth using the appropriate materials (i.e. napkins, paper towels). Interview with the QMRP at the residential facility revealed that Client #6 wipes her mouth independently. At no time did the support staff offer Client #6 a napkin and/or paper towel to wipe her mouth. The was no evidence Client#6 was provided disposables (napkins or paper towel) with which to clean her mouth when she drooled.	W 455	Cross reference W112 #1	
W 474	483.480(b)(2)(iii) MEAL SERVICES Food must be served in a form consistent with the developmental level of the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that a form consistent with the developmental level of the client for one of eight clients included in the sample. (Client #6) The finding includes: Observations of the dinner meal conducted on February 6 and 8, 2007 revealed that Client #6 was served a pureed dinner while feeding independently. Interview with the Residential Counselor February 6, 2007 revealed that Client # 6 in on a pureed diet.	W 474		

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W 474	Continued From page 51 Interview with the facility's dietician and Qualified Mental Retardation Professional (QMRP) on February 8, 2007 revealed that Client #6 is on a " Finely Chopped" diet. Review of Client #6's current Physician's Orders and Nutritional Assessment dated May 5, 2006 on February 8, 2007 at 2:33 PM revealed that Client #6 is prescribed a 1200 calorie low cholesterol fine chopped diet. There was no evidence the client receive her meals in the texture (fine chopped) as prescribed.	W 474	Food services staff dietician and direct care staff received a memo on 2-9-07 regarding client # 6 correct diet orders (see attachment)	2/9/07
W 484	483.480(d)(3) DINING AREAS AND SERVICE The facility must equip areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each client. This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure dining supplies were provided to meet the developmental needs of seven of eight clients in the sample. (Clients #1, #3, #7 and #8, #9, and #10) The findings include: a. During dinner observation on February 06, 2007, Clients #1, #3, #7 and #8 were observed eating their prepared meals. The clients were not offered condiments, such as salt or pepper and there were no condiments available in the dining room. b. During breakfast on February 7, 2007 staff was observed to feed Clients #9 and #10 using built-up handle teaspoons. Interview with staff indicated that Client #9 participates in feeding	W 484	A.Condiments will be provided during meals. Cross reference W159 # 8 pg. 21	

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W 484	Continued From page 52 himself. Hand-over hand assistance is encouraged by residential staff, however the client's desire to assist and level of participation is inconsistent. At the time of the observation, there was no evidence the client was provided the opportunity to participate in self-feeding using the adaptive spoon with hand-over-assistance. c. On February 7, 2007 during breakfast, Client # 10 was offered his water from a spoon. Interview with staff indicated the client has difficulty consuming liquids. Further interview with staff and the review of the feeding protocol posted on the bulletin board and the clients record revealed the client should receive all liquids thickened to honey consistency except water. Record verification indicated a recommendation was made for Client #10 to have a special cup to improve his fluid intake on January 2007. At the time of the survey, there was no evidence the special cup had been provided for the client.	W 484	B.QMRP will retrain staff on client # 9 feeding protocol. Cross reference W249 #2 C. QMRP ordered adaptive cup on 3-12-07. cross reference W436 #4	3/20/07 3/12/07
W 488	483.480(d)(4) DINING AREAS AND SERVICE The facility must assure that each client eats in a manner consistent with his or her developmental level. This STANDARD is not met as evidenced by: Based on observation, staff interview, and review of the activity schedule, the facility failed to assure that eight out of eight clients in the sample ate in a manner consistent with his or her developmental level. (Clients #1, #2, #3, #4, #5,# 6, #7 and #8) The finding includes: 1.Cross Refer to W120,2. During observation of	W 488		

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W 488	Continued From page 53 the lunch meal at the day program on February 07, 2007, Client #7 was provided with a plastic spoon to eat her 1600 calorie low cholesterol diet. During observation of the dinner meal at the facility, Client #7 was provided with a plastic spoon to eat her meal. Interview with the facility staff revealed that regular utensils are not provided or encouraged for the client to use at mealtimes. There was no evidence that the opportunity to learn to utilize varied utensils for eating was made available during the observations. 2. During observation of the dinner meal on February 6, 2007, Client # 1 was observed to eat his meal with a plastic fork. The client was observed to use his fingers to push the food on the fork and to prevent from falling to the plate. Interview with the nutritionist on February 7, 2007 revealed the client should be provided metal silverware with which to eat their meals. There was no evidence the client was provided appropriate eating utensils to eat his meals. 3. On the morning of February 9, 2007 waffles, syrup and sausage were include on the breakfast menu. Clients were observed to not have the waffles cut to bite size pieces but to bite directly from the whole pieces of waffles and sausage. There was no evidence that appropriate eating utensil were provided to the clients able to use them or that the foods were cut to bite size pieces for the clients who needed assistance. 4. The facility failed to ensure clients were provided the opportunity to participate in family style dining. a. At each observed meal time, (dinners and breakfasts) the food was provided from the	W 488	1. Lunch is delivered in the classroom in disposable containers. Disposable utensils are provided for all clients. A variety of plastic utensils will be provided for client # 7 and all clients 2. Metal utensil will be provided to client # 7 and all clients during breakfast and dinner. 3. Staff was trained on family style dining on 3-14-07. Training will be on going. 4. Cross reference # 3	3/6/07 3/13/07 3/14/07 3/14/07

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W 488	Continued From page 54 kitchen in serving bowls for all clients, except those clients on special diets. Staff were observed to serve the food from the bowls to the plates for the clients. Interview with staff revealed that some of the client ' s had the ability to serve their own plates with supervision from staff. Further interview with staff indicated that with hand over hand assistance other client ' s could participate in the family style dining experience. There was no evidence the clients were provided an opportunity to participate in family style dining. b. On February 7, 2007, strafoam plates with lids were observed on the trays of food brought from the kitchen for the clients. Interviews with staff, the cook and the dietitian all revealed clients, such as Client #1 and #4 (who received their meals on a styrafoam plate) have their food served on styrafoam plates to ensure that they receive the prescribed type and portions of food for their therapeutic diets. There was no evidence the clients were provided an opportunity to participate in family style dining or that a learning opportunity was provided for these clients to select the appropriate type and amounts of foods. 5. During breakfast on February 7, 2007, Client # 5 was observed wearing a long bib tied around his neck. The end of the bib was used as a placemat, as it extended from the client ' s neck to underneath the plate, which contained the food . When the client moved backward from the table in his wheelchair, the plate moved with the client, causing him to almost spill the leftover food onto his clothing, prior to staff intervention. Interview with staff indicated the bib is used to prevent the client from soiling his clothing. There was no evidence there was no evidence the client was	W 488	4b. The food service staff will inquire about portion control serving utensils. Until that time clients with special diets will remove their food from Styrofoam containers and place meals on plates. 5.QMRP will retrain staff on feeding protocol for client #5 by 3-20-07. Placemats will be provided by 3-20-07 (See attachment sign in)	3/20/07

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W 488	Continued From page 55 provided with an appropriate placemat for use during his meal. 6. On February 7, 2007 during breakfast, Client # 10 was offered his water from a spoon. Interview with staff indicated the client has difficulty consuming liquids. Further interview with staff and the review of the feeding protocol posted on the bulletin board and the clients record revealed the client should receive all liquids thickened to honey consistency except water. Record verification indicated a recommendation was made for Client #10 to have a special cup to improve his fluid intake on January 2007. At the time of the survey, there was no evidence the special cup had been provided for the client. 7. Cross refer to W484, b. The facility failed to ensure Client #10 was actively encouraged to assist in feeding himself to the extent of his capability and in accordance with his assessed need.	W 488	6. QMRP ordered the arrest cup on 3-12-07. cross reference W436 #4 7. QMRP trained staff on client # 10 feeding protocol 3-7-07 cross reference W249 #3	3/12/07

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I 000	INITIAL COMMENTS A licensure survey was conducted on February 9, 2007. A random sampling of eight clients was selected from a population of twenty-nine (29) residents with various disabilities. The findings were based on observations, interviews with clients, family members, facility staff, school and day program staff, as well as the review of client habilitation and administrative records, including incident reports.	I 000		
I 041	3502.2(a) MEAL SERVICE / DINING AREAS Modified diets shall be as follows: (a) Prescribed in the resident ' s Individual Habilitation Plan and the record of the prescription for the modified diet shall be kept in the resident ' s record; This Statute is not met as evidenced by: The finding includes: See Federal Deficiency Report - Citation W474.	I 041	a. Client #6's diet order was placed in her IHP on 3/16/07	3/16/07
I 052	3502.10 MEAL SERVICE / DINING AREAS Each GHMRP shall equip dining areas with tables, chairs, eating utensils, and dishes designed to meet the developmental needs of each resident. This Statute is not met as evidenced by: The findings include: See Federal Deficiency Report - Citations W484 and W488.	I 052	Food services will provide appropriate utensils and condiments to clients. Cross reference W189 #8 pg 21	3/13/07

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I 091	Continued From page 1	I 091		
I 091	3504.2 HOUSEKEEPING Housekeeping and maintenance equipment shall be well constructed, properly maintained and appropriate to the function for which it is to be used. This Statute is not met as evidenced by: Based on observation interview and record, the GHMRP facility failed to ensure the temperature in various areas of the building was maintained within a normal comfort zone. The findings include: See Federal Deficiency Report - Citation W429.	I 091	The facilities department will ensure that and equipment check and weather proofing occurs in fall prior to winter and in the spring. See W104 # 4 pg. 2	
I 160	3507.1 POLICIES AND PROCEDURES Each GHMRP shall have on site a written manual describing the policies and procedures it will follow which shall be as detailed as is necessary to meet the needs of each resident served and provide guidance to each staff member. This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure its written manual describing the policies and procedures it will follow was detailed and met the residents' needs. The finding includes: 1. The GHMRP failed to have a policy on restricted access to the facility. On February 6, 2007 at 7:15 AM the main exit doors were observed to be locked. Interview with several direct care staff during the survey, indicated that	I 160	HRC committee approved a policy for use of magnetic locks. Cross reference W104 #3 on 3-15-07	

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I 160	Continued From page 2 at times the door are not locked during the day, the doors were observed to remain locked throughout the survey. Interview with the Residential Program Manager (RPM) revealed that the locks were installed to prevent clients who have targeted behavior of abscondence from attempting to exit the facility. Additionally, the RPM indicated that this practice prevents unauthorized individuals from entering the building. There was no evidence the GHMRP had established a written policy on the use of locked doors. 2. (See Federal Deficiency Report Citation W149)	I 160	Cross reference W104 #3	
I 228	3510.5(e) STAFF TRAINING Each training program shall include, but not be limited to, the following: (e) Resident ' s rights; This Statute is not met as evidenced by: Based on observation, interview, and record review, the GHMRP failed to ensure staff were effectively trained in residents rights. The findings include: See Federal Deficiency Report - Citations W125, W137, W153, W154. and W247.	I 228	Staff will be trained on clients Rights Policy annually. The first Training is scheduled 4/4/07	
I 261	3512.2 RECORDKEEPING: GENERAL PROVISIONS Each record shall be kept in a centralized file and made available at all times for inspection and	I 261		

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I 261	Continued From page 3 review by personnel of authorized regulatory agencies. This Statute is not met as evidenced by: Based on observation and interview the GHMRP failed to ensure records were available for inspection at all times by personnel of authorized regulator agencies. The finding includes: During the entrance conference on February 6, 2007, a request was made for various documents to be provided on February 7, 2007 during the survey was made. Interview with the Residential Program Manager (RPM) on February 8, 2007 indicated the team would review the personnel information on February 9, 2007. Interview with the RPM on February 9, 2007 revealed the the personnel information was not available.	I 261	Residential Manager will ensure that records are available to the survey team upon request	
I 291	3514.2 RESIDENT RECORDS Each record shall be kept current, dated, and signed by each individual who makes an entry. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each entry in the residents' record was signed by the individual making the entry. The findings include: See Federal Deficiency Report - Citation W114.	I 291	QMRP will ensure that all official documentation is signed and dated. All documentation not signed will be marked as a draft.	
I 355	3518.4(a) DISCHARGE / TRANSFER POLICIES PROCEDURES	I 355		

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I 355	Continued From page 4 Each GHMRP shall plan for voluntary or involuntary transfer or discharge of a resident on a non-emergency basis and shall provide the following: (a) Sixty (60) days notification to appropriate individuals or sponsoring agencies of reasons for the need to transfer or discharge; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of a transfer plan for Resident #2. The finding includes: (See Federal Deficiency Report - Citation W202)	I 355	QMRP will ensure that written notification for transfer are given to all appropriate agencies Cross reference W159 #5	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health, Health Facilities Division was notified of unusual incidents that substantially interfered with a resident ' s health.	I 379		

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I 379	Continued From page 5 The finding includes: See Federal Deficiency Report - Citation W153.	I 379	**I 401-W120** An OT assessment was scheduled for client #7 (see attachment). For client # 6 had an assessment to see if she could wipe her mouth. An informal reinforcement of her ability to wipe her mouth will continue. **W159** 2. Client #4 will receive adaptive skills to improve his eating skills 4. Direct support staff will be retrained on client #7 BSP 5. A transition plan will be developed for client #2. A signed and date BSP was placed in the record of Client #5. **W322** 2. Client #7 participated in an Ophthalmology appointment on 3/13/07 3. The appointment diary has been amended to include labs and other reports. **W436** A. For client #4 a goal to care for his glasses was added and the daily use of his glasses was documented on his MAR. B. Client #1 also received a goal to care for his glasses and client #2 no longer requires glasses. A,B,C. Documentation of wheelchair is attached to this plan of correction. Nurses will monitor the state of wheelchairs on a monthly basis. Adaptive cup was ordered on 3/12/07 and staff was trained on the use of the cup 3/12/07	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the provision of professional services. The findings include: See Federal Deficiency Report Citations - W120, W159, W322, W331, W338 and W436.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure habilitation and training was provided. The findings include: See Federal Deficiency Report - Citations W193, W242, W249, and 252.	I 422		

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I 379	Continued From page 5 The finding includes: See Federal Deficiency Report - Citation W153.	I 379	An OT assessment was scheduled for 3-21-07 for client #7 upon assessment client #6 demonstrated that she is able to wipe her mouth. See W159	3/21/07
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure the provision of professional services. The findings include: See Federal Deficiency Report Citations - W120, W159, W322, W331, W338 and W436.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, interview and record review, the GHMRP failed to ensure habilitation and training was provided. The findings include: See Federal Deficiency Report - Citations W193, W242, W249, and 252.	I 422	**I 422-W193** Staff was retrained on client #7 BSP. Staff was also trained on client #1 BSP **W242** Client #6 ability to wipe her mouth will be monitored and reinforced in day program and at home. **W249** Staff will be retrained on client #9 feeding protocol. 3. Staff will be retrained on client #10 feeding protocol. **W252** Staff was retrained on implementing feeding protocol.	

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I 500	3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federal laws. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the protections of each clients rights. The findings include: See Federal Deficiency Report - Citations W125, W137, W149, W153, W154, W156, and W264.	I 500	**W125** Policy was drafted for use of magnetic locks for ICF-MR and brought to the HRC on 3/15/07 **W137** Client #4 clothes was inventoried for perfect fitting. All ill-fitting clothes will be removed **W149** Residential Program Managers are the administrators who review all unusual incidents. The residential population Program Manager will ensure that all incidents are removed in a timely manner	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G002	A BUILDING _____ B WING _____	02/09/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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R 000	INITIAL COMMENTS A licensure survey was conducted from February 9, 2007. A random sample of eight clients was selected from a residential population of 29 individuals with varying degrees of mental retardation. Personal records for staff were requested from the Residential Program Manager during the survey. Interview with the program manager on February 9, 2007 revealed the Personnel records, including the criminal background checks were not available for review. The results of criminal background checks therefore continues to be pending.	R 000	**I. 500 Continued** 1. The incident reporting policy is being reconstructed to better meet the needs of our clients at the program level. This the response to W153 Clear Identification of Administrator. This the response to W153 Clear definition between DDS and DOH requirements. This the response to W153 All follow up information pertaining to this incident is disclosed This the response to W154 Q.I. Investigation policy process. This the response to W154 Review policy with Beth This the response to W156 Personnel Records are available for review	